
# The State of Retiree Health Benefits: Historical Trends and Future Uncertainties

Patricia Neuman, Sc.D.
Vice President and Director, Medicare Policy Project
The Henry J. Kaiser Family Foundation

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**Statement of Patricia Neuman, Sc.D.**

Thank you, Mr. Chairman and Members of this Subcommittee. I am pleased to be here to testify on the state of retiree health coverage. I am Patricia Neuman, a Vice President of the Henry J. Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project. I am also an associate faculty member at the Johns Hopkins University School of Public Health in the Department of Health Policy and Management.

Employer-sponsored health plans play a critical role in providing health insurance for retirees—both those who are considered early retirees between the ages of 55 to 64 and for retirees on Medicare. For just over three million retirees ages 55 to 64, employer plans bridge a potentially risky gap in coverage between the time they leave employment and when they are first eligible for Medicare. This coverage provides needed health insurance for early retirees at a time in their lives when they are likely to face increasing health problems and might otherwise find comprehensive, affordable health insurance difficult to obtain. For one in three seniors with Medicare, employer-sponsored health plans have been a vital source of supplemental coverage and the primary source of prescription drug coverage.

The past decade has witnessed a steady erosion of retiree health benefits. This erosion threatens to increase the number of early retirees who are uninsured and to diminish needed supplemental coverage for seniors on Medicare. Sustained double-digit increases in health care costs for retirees are expected to result in continued cutbacks in the future. Within the last two years, several large employers have announced plans to cut back on their retiree health obligations. For example, Sears Roebuck and Company recently announced that, starting January 2005, retiree health benefits will no longer be available for new hires and will be eliminated for all employees under age 40.[1] Aetna recently announced it would cut subsidies for retiree health benefits for those who retire in 2004.[2] Lucent Technologies, Inc. did not eliminate benefits but made severe cuts in retiree health coverage and substantially raised retiree contributions to premiums.[3]

Against this backdrop, two recent events are being monitored for their potential impact on the future of retiree health coverage. First, the *Medicare Prescription Drug, Improvement, and Modernization Act*, enacted in 2003, provides $88 billion in direct and indirect subsidies for employers to encourage them to maintain health benefits for Medicare-eligible retirees. Clearly a hot-button issue throughout the debate over the new law was the question of whether a new Medicare drug benefit would accelerate the erosion of highly-valued retiree health benefits. How employers respond to these incentives is a critical concern, and one that the Foundation will continue to monitor as part of its Kaiser/Hewitt 2004 survey of employers offering retiree health benefits.

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[1] Sandra Guy, "Sears says benefit cuts meant to help it compete," *Chicago Sun-Times*, 28 January 2004, Financial Section, p. 33.
[2] Diane Levick, "Aetna Accused of Breaking Promises," *Hartford Courant*, 1 May 2004, Business Section, p. E1.
[3] Ellen Schultz and Theo Francis, "How Lucent's Retiree Programs Cost It Zero, Even Yielded Profit," *Wall Street Journal*, 29 March 2004, p. A1.

The second recent development that could impact the future of retiree health benefits, particularly for Medicare-eligible retirees, is the proposed final rule adopted by the Equal Employment Opportunity Commission, making it easier for employers to coordinate benefits with Medicare, without violating the Age Discrimination in Employment Act.

Given the value of employer-sponsored benefits to retirees, the sustained erosion of this coverage has the potential to undermine the health and financial security of retirees as they grow older and underscores the need to monitor trends in retiree coverage and their impact on aging Americans.

## The Role of Retiree Health Today

### Early Retirees

More than three million retirees between the ages of 55 and 64 rely on employer-sponsored plans for their health insurance coverage (Exhibit 1). For early retirees, employer plans generally provide access to relatively affordable and comprehensive coverage. Without this coverage, many retirees who are pre-65 and too young for Medicare would be hard-pressed to find comparable, affordable coverage on their own. If an employer terminates retiree health benefits, the retirees do not have a right under COBRA to purchase health coverage through a plan offered by their former employer.

Older adults without employer-sponsored benefits often turn to the non-group individual market for health insurance coverage. Unfortunately, the individual market has proven to be a less than reliable source of affordable coverage—particularly for those with either a history of medical problems or those with modest incomes. Premiums in the individual market can be expensive for early retirees, presenting a considerable financial hurdle for those living on fixed incomes. And often, their benefits are less generous than those typically offered to retirees by employers.

For example, a 60-year old man in Baltimore City who is a non-smoker could find a policy with a $235 monthly premium, a $500 deductible, a 20% coinsurance on office visits after the deductible, and a $500 limit on prescription drug coverage.[4] He could find a policy with a lower premium of $159/month but would face both a higher deductible and higher coinsurance. By contrast, a retiree of the same age would most likely pay considerably less in monthly premiums and have more generous benefits. According to the 2003 Kaiser/Hewitt Survey on Retiree Health Benefits, the weighted average retiree premium contribution was $166 per month in 2003. Even if retiree contributions to premiums increased by 20% between 2003 and 2004, a retiree in an employer plan would pay far less in premiums than they would in the individual market. Also, unlike the example of the policy in the individual market where caps on pharmacy benefits are becoming increasingly common, absolute limits on drug benefits offered by employer plans are rare.

Some early retirees—particularly those with health problems—are unable to buy insurance in this market at any price; and those who can, are likely to face substantially

[4] Quotes from EHealthInsurance.com, https://www.ehealthinsurance.com/ehi/Welcome.ds, accessed May 11, 2004.

higher premiums. According to two reports prepared for the Kaiser Family Foundation, one by Karen Pollitz and colleagues from Georgetown University, and the other by Deborah Chollet and Adele Kirk of the Alpha Center, insurers in the individual market tend to underwrite aggressively—screening applicants for pre-existing conditions, excluding coverage for the services people with specific health conditions need, or denying coverage altogether. In states where insurers are not required to guarantee issue, for example, insurers may deny coverage for such common conditions as rheumatoid arthritis, chronic headaches, angina, kidney stones, heart attacks, and stroke.

High-risk pools are another option in 31 states. Retirees in states with high-risk pools can buy coverage, without regard to medical history. Premiums, however, tend to be higher than those in the individual market, which limits the number of people who can afford to avail themselves to this opportunity.

Given these limitations, the erosion of employer-sponsored retiree health coverage puts early retirees at risk of being uninsured. While health insurance matters to people of all ages, it is especially important to retirees who, as they grow older, tend to experience more acute and chronic health problems. Mid-life and older adults are far more likely than younger adults to report being in fair or poor health and to have chronic health conditions such as heart disease, arthritis, and diabetes. They tend to have a greater need for medical services that can be prohibitively expensive without the financial protection offered by health insurance. And, at this stage in their lives, if they are unable to purchase health insurance in the individual market, they may not be in a position to return to work or find another job that offers health insurance.

Retirees 65+ on Medicare

Seniors, unlike early retirees, are fortunate to have Medicare as a safety-net insurer and as their primary source of health insurance. Still, many have come to rely on employer-sponsored retiree plans to provided needed assistance in supplementing Medicare's benefits. The erosion of retiree benefits to date, coupled with predictions of future terminations in coverage, higher premiums and cost-sharing, and additional cutbacks in benefits (discussed below) pose serious concerns for the financial security of retirees.

Today, more than a third of all people ages 65+ (about 11 million seniors) have supplemental coverage from an employer plan (Exhibit 2). Employer plans, like other forms of supplemental coverage, assist with Medicare's cost-sharing requirements and help pay for services, such as prescription drugs, not covered by Medicare. In fact, employer-sponsored plans are the primary source of prescription drug coverage for people on Medicare.

Retiree health benefits for seniors are typically more generous than other sources of supplemental coverage with the exception of Medicaid, which is only an option for those with low incomes. In general, employer plans have annual out-of-pocket limits that help to protect retirees from catastrophic spending. They also cover prescription drugs but without separate drug deductibles or benefit limits. By contrast, most Medigap polices do not cover prescription drugs, and the three standard policies that do cover pharmacy costs all have caps on these benefits. Likewise, about a third of enrollees in Medicare Advantage in 2003 are in plans that do not provide drug coverage,

and among enrollees in plans with drug coverage, about one in five face an annual cap of $750 or less.[5] At the same time, retiree contributions to premiums for employer-sponsored plans tend to be substantially lower than premiums charged for Medigap policies with more limited drug coverage, giving seniors far more bang for their buck.

Because of their relatively generous benefits, employer plans help shield retirees from substantial cost burdens underscoring why the erosion of retiree health coverage has been and continues to be a serious concern. Seniors with employer-sponsored coverage have substantially lower rates of cost-related prescription drug skipping than do those with other sources of coverage. Only 15 percent of those with employer-based coverage reported medication skipping for any cost-related reason compared to 39 percent of those in a Medicare HMO, and 25 percent with other private coverage, according to preliminary findings from a 2003 survey of seniors being conducted by the New England Medical Center, the Kaiser Family Foundation and the Commonwealth Fund (Exhibit 3).

**Rising Health Costs and the Erosion of Retiree Benefits**

The prevalence of retiree heath coverage has declined dramatically over the past 15 years. Among large employers (200+ workers), who are far more likely than small or mid-sized employers to offer retiree health benefits, the percentage offering retiree coverage has dropped from 66 percent in 1998 to 38 percent in 2003, according to the annual Kaiser/HRET Employer Health Benefits Survey. This decline is a function of the rising number of employers terminating coverage, as well as fewer new companies offering retiree health benefits due to rising health care costs (Exhibit 4).

Sustained double-digit increases in retiree health costs are clearly a major factor in the erosion of coverage and are a significant concern among employers. According to the 2003 Kaiser/Hewitt Survey on Retiree Health Benefits, the total cost of providing retiree health benefits increased by an estimated 13.7 percent between 2002 and 2003. This growth is essentially the same rate observed among active workers during this same time frame, according to the Kaiser/HRET Survey (Exhibit 5).

Caps on Future Retiree Health Obligations

In response to these cost increases and changes adopted in the early 1990s by the Financial Accounting Standards Board (FASB) that required firms to account for their future retiree health obligations, employers have implemented a number of strategies to curb their costs. Of note, our survey found that roughly half of all large (1,000+ workers) private-sector employers that offer retiree health benefits to 65+ retirees have imposed caps on their future obligations for retiree health coverage (Exhibit 6). Among firms that have caps on their retiree health obligations, nearly half have already hit the cap, and another third say they are likely to hit the cap in the next one to three years.

[5] Achman and Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999-2003, and Special Topics*, December 2003.

Efforts to Limit Employers' Retiree Health Costs

While there have been a number of highly publicized decisions by employers that resulted in the termination of benefits for current retirees—such as the Bethlehem Steel bankruptcy that resulted in a loss of health benefits for 95,000 retirees—our survey suggests that terminations are more likely to affect *future* retirees (current workers) than *current* retirees. Among surveyed employers offering health benefits to retirees, ten percent said they had eliminated subsidized health benefits for *future* retirees in the past year (Exhibit 7). Most of these terminations affect a subset of employees, generally those who were hired after January 1, 2003 (e.g., "new hires").

Far more common than benefit terminations are increases in retiree contributions to premiums and cost-sharing requirements. In the past year, 71 percent of participating large private-sector firms increased retiree contributions to premiums and 57 percent increased retirees' prescription drug cost-sharing requirements. More than a quarter of all surveyed employers said they increased hospital copayments (26%) and out-of-pocket limits (29%), and more than a third reported increasing deductibles (34%) and physician office visit copayments (37%) in the past year (Exhibit 8).

Looking to the near future, the Kaiser/Hewitt Survey on Retiree Health Benefits offers reason to suspect that the trend of declining retiree health benefits will continue; however, it is important to emphasize that this survey was conducted prior to the enactment of the Medicare legislation and does not reflect employers' likely response to the changes and incentives in the new law.

When asked about their likelihood of discontinuing coverage for their retiree populations, only two percent said they are very or somewhat likely to terminate all subsidized health benefits for *current* retirees. Again, this suggests that current retirees are largely shielded from terminations in coverage. However, the news was far less promising for current workers, or the retirees of the future. One in five surveyed employers said they are very or somewhat likely to terminate all subsidized health benefits for *future* retirees. Serious consideration is also being given to providing access to health benefits but having retirees themselves pay all of their costs. A quarter of surveyed firms reported that they are very or somewhat likely to require retirees to pay 100 percent of the cost of coverage (Exhibit 9).

Premium and cost-sharing increases are far more likely in the next few years, according to employers in our survey. To help ameliorate the effect of rising retiree health care costs, many employers said they would seriously consider major changes in their benefits, including increasing retiree contributions to premiums (86 percent), raising cost-sharing for prescription drugs (85 percent), and increasing deductibles (75 percent). And roughly two-thirds of all surveyed employers said they are very or somewhat likely to increase physician office visit copayments (69 percent) and out-of-pocket limits (65 percent) (Exhibit 10). Again, it is important to note that these findings are from the summer of 2003, prior to the final passage of the Medicare legislation.

**Medicare Modernization Act**

There is substantial interest in how the Medicare drug law will influence employers' decisions regarding retiree health benefits. The issue received considerable

attention during the legislative debate and contributed to the final shape of the Medicare law. Concerned about the possibility that a new Medicare benefit would accelerate the erosion of highly-valued retiree health benefits, policymakers designed the law to include financial incentives for employers to remain a primary source of drug coverage for the Medicare population.

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* encourages continued coverage of retiree health benefits by offering employers considerable financial incentives, flexibility, and multiple options for coordinating their plans with Medicare. The new law includes tax-free direct subsidies equal to 28 percent of total drug costs between $250 and $5,000 per retiree if the employer plan provides drug coverage that is at least actuarially equivalent to the standard Medicare drug benefit. Today, most employers offer drug coverage that is of greater actuarial value than the standard Medicare drug benefit. However, the law does not preclude employers from scaling back drug coverage to the standard Medicare level and still receiving the financial subsidy.

How employers will respond to the new Medicare legislation with respect to benefits offered to Medicare-eligible retirees is a critical concern but will only become apparent after employers have had sufficient time to understand and analyze the implications for their firms. Employers have a number of options to consider. They could, for example:

- Accept the 28 percent subsidy and maintain benefits at their current value, or modify their benefit design to be equivalent in value to the standard Medicare drug benefit;

- Decline the subsidy, and, instead, choose to wrap around or supplement the new Medicare Part D benefit in some manner; however, if they take this approach, their contributions will not count toward retirees' out-of-pocket limit; or

- Terminate retiree health coverage altogether.

Some suggest that the 28% subsidy will allow employers to "stay in the game" by alleviating some of the cost pressure. Others are concerned that the new Medicare benefit may give employers an opening to cut back on their retiree health obligations, which is a concern because the benefit is substantially less generous than the typical employer plan.

**Concluding Thoughts**

Today, millions of retirees—both pre-65 and seniors on Medicare—enjoy the financial protections offered by employer-sponsored retiree health benefits. But, all signs point to an erosion of this coverage in the years ahead—an erosion that was predicted prior to the enactment of the Medicare drug law.

It now seems clear that fewer workers can count on such coverage when they retire. Fewer employers are offering retiree health benefits, and those that do are clearly looking for ways to limit their own financial liability. As a result, the current generation of

workers will be far less likely than their parents' generation to receive the same level of employer-sponsored retiree health benefits, if they get retiree coverage at all.

How employers will respond to the new Medicare drug law is clearly a critical concern but remains unclear at this time. The drug benefits offered by employers to Medicare-eligible retirees are far more generous than the standard drug benefit set forth in the new law. The typical employer plan does not impose a separate drug deductible nor interrupt coverage at a given benefit level until a retiree's drug spending reaches a set out-of-pocket limit (e.g., no doughnut hole). The relative generosity of employer coverage, as compared to the forthcoming Medicare drug benefit, could add to concerns among retirees about losing valued drug coverage.

## References


Achman, L. and M.Gold, *Trends in Medicare+Choice Benefits and Premiums, 1999-2003, and Special Topics*, prepared by Mathematica Policy Research, Inc. for The Commonwealth Fund, December 2003.

Chollet, D., and A. Kirk, *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States*, prepared by the Alpha Center for The Henry J. Kaiser Family Foundation, March 1998.

Congressional Budget Office, letter to Representative William "Bill" M. Thomas, 14 November 2003, Washington, D.C.

Congressional Budget Office, letter to Senator Don Nickles, 20 November 2003, Washington, D.C.

Equal Employment Opportunity Commission. *Age Discrimination in Employment Act; Retiree Health Benefits*, 29 CFR Parts 1625 and 1627, RIN 3046-AA72. Washington, D.C.: EEOC, 2004.

Erie County Retirees Association v. County of Erie, 220 F.3d 193 (3d Cir. 2000).

General Accounting Office, "Retiree Health Benefits: Employer-Sponsored Benefits May Be Vulnerable to Further Erosion," *Report to the Chairman, Committee on Health, Education, Labor, and Pensions, U.S. Senate*, GAO-01-374, May 2001.

Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, December 2003.

Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Survey*, September 2003.

McArdle, F., P. Neuman, M. Kitchman, K. Kirland, and D. Yamamoto, "Large Firms' Retiree Health Benefits Before Medicare Reform: 2003 Survey Results," *Health Affairs Web Exclusive*, 14 January 2004, http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.7v1/DC1, accessed May 11, 2004.

Pollitz, K., R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* prepared by The Institute for Health Care Research and Policy, Georgetown University, and K.A. Thomas and Associations, for The Henry J. Kaiser Family Foundation, June 2001.